Washington Metropolitan Area Transit Commission

2014 Carrier Annual Report Form

Read the accompanying instructions carefully before completing this form.

1. CARRIER INFORMATION:

635	Metro Day Treatment Center, Inc.
*WMATC No.	*Name of Carrier (as shown on certificate of authority)

6856 Eastern Avenue, N.W., #376		Washington	DC	20012-2112
*Street Address of Principal Place of Business	Apt./Suite	City	State	Zip
Mailing Address (if different from street address)	Apt./Suite	City	State	Zip

(202) 829-1707		(202) 829-0616	
*Telephone	Other Telephone	Fax	E-mail

2. OTHER PASSENGER CARRIER AUTHORITY (if applicable, list carrier/permit number):

2064678			
USDOT No.	DCTC No.	Virginia DMV passenger carrier No.	Maryland PSC No.

3. CARRIER CONTACT PERSON (at mailing address to whom we should direct inquiries):

Mr. Kevin M. Mattison	Transportation Manager
*Name	*Title

(202) 829-1707		(202) 829-0616	
*Telephone	Other Telephone	Fax	E-mail

4. REGISTERED AGENT INSIDE THE METROPOLITAN DISTRICT FOR SERVICE OF PROCESS

*Complete section 4 only if the principal place of business in section 1 is outside the Metropolitan District. The Metropolitan District includes the District of Columbia, Prince George's Co., Montgomery Co., Alexandria, Arlington, Fairfax, Falls Church, and Dulles Airport. For a full description, see www.wmatc.gov.

Name of Registered Agent for Service of Process	Telephone	E-mail

Agent Address (must be inside Metropolitan District)	Apt./Suite	City	State	Zip

5. ***CHANGES:** Describe any merger, consolidation or other change in management, ownership, control, or form of organization that occurred after the previous year's annual report was filed, or if not applicable, after the carrier's certificate of authority was issued. If no changes are entered below, the carrier certifies that no such changes have occurred.

6. ***LIST OF REVENUE VEHICLES USED IN WMATC OPERATIONS:** (1) list your vehicles below **or** (2) attach a complete vehicle list to both pages of this form. If you have more than 10 vehicles in your fleet, you must use option 2. Include **all** required information.

Fleet No. if applicable	*Model Year	*Make	*Vehicle VIN (17 digits)	*License Plate Number	*State Registered	*Seating Capacity	Wheelchair Lift or Ramp Yes/No
MATC	2003	FORD	1FBSS31L53HB43937	R44083	DC	9	YES
MOTC	2012	FORD	1FBSS3BL5CDA37316	B45152	DC	15	NO
MOTC	2004	FORD	1FBSS31L54HB12804	B44671	DC	15	NO

7. ***CERTIFICATION:**

I certify that this report, including any attachments, was prepared by me or under my supervision, that I have examined it, and that the information contained in it is true, correct, and complete as of this date.

KEVIN MATTISON
***Name** (type or print)

***Signature**

TRANSPORTATION MANAGER
***Title** (not required for sole proprietors)

1/31/14
***Date**